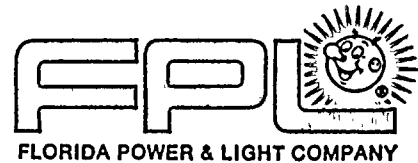


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DEC 13 1985

L-85-459

Dr. J. Nelson Grace
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta Street N.W., Suite 2900
Atlanta, Georgia 30303

Dear Dr. Grace:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Inspection Report 250-85-30 & 251-85-30

Florida Power and Light Company has reviewed the subject inspection report and a response is attached.

In reference to LER 250-85-21 which is discussed in your report, we plan to submit a revision by December 20, 1985.

There is no proprietary information in the report.

Very truly yours,

J. W. Williams, Jr.
Group Vice President
Nuclear Energy Department

JWW/JA:mls
Attachment

cc: Harold F. Reis, Esquire
PNS-LI-85-490/2

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ATTACHMENT

Re: Turkey Point Units 3 and 4
Docket No. 50-250, 50-251
IE Inspection Report 250-85-30 and 251-85-30

FINDING 1:

Technical Specification (TS) 6.8.1 requires that written procedures and administrative policies be established, implemented and maintained that meet or exceed the requirements and recommendations of sections 5.1 and 5.3 of ANSI N18.7-1972 and Appendix A of USNRC Regulatory Guide 1.33.

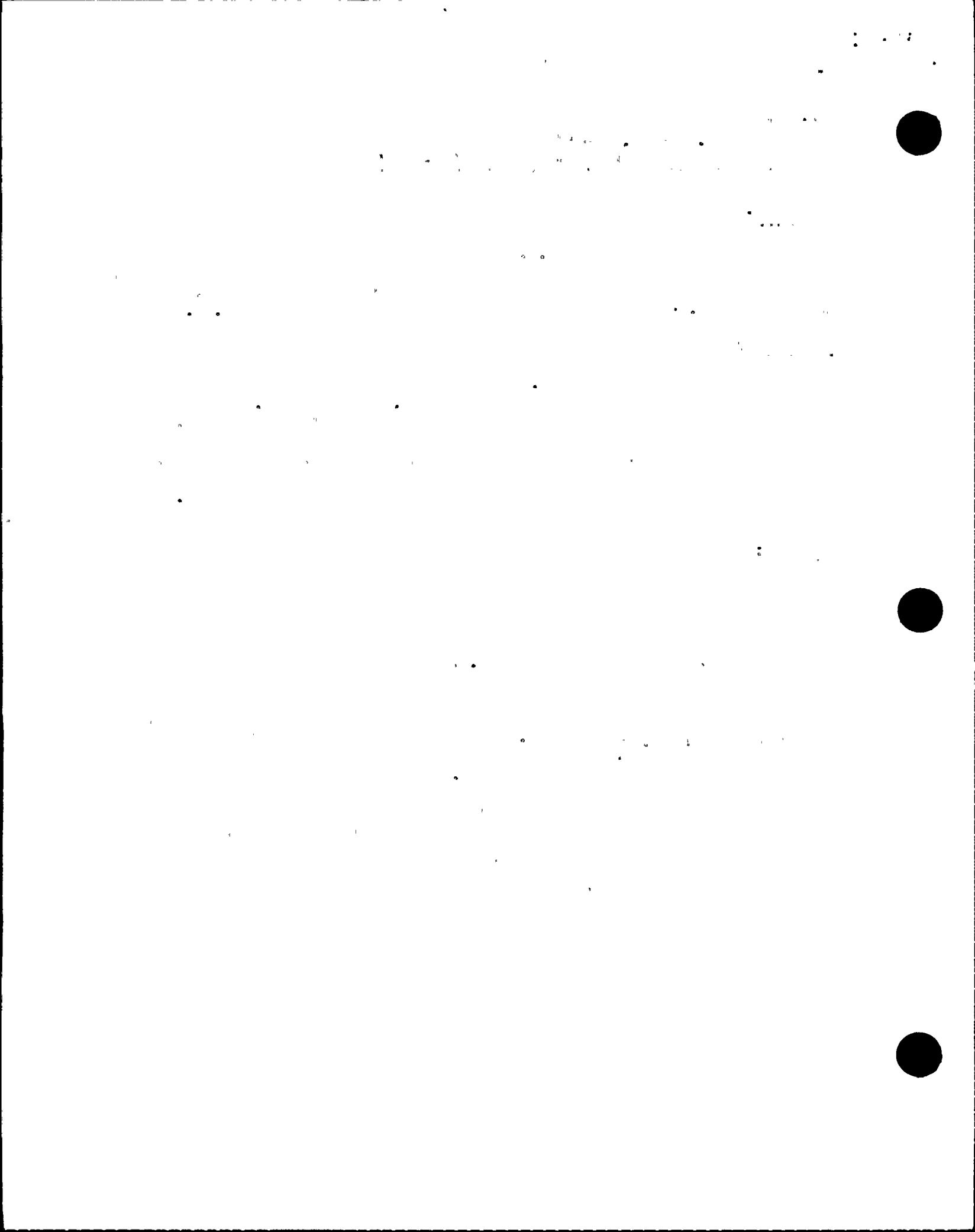
FINDING 1a:

Operating Procedure (OP) 3204.1, dated December 20, 1984, entitled Residual Heat Removal Periodic Test, requires, in section 8.8.4, that a second person independently verify that four breakers are locked open.

Contrary to the above, on September 5, 1985, section 8.8.4 of OP 3204.1 was not implemented, in that the required independent verification was not performed prior to running the Unit 4A residual heat removal pump.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the finding was that the operator misread the step and only verified the light indication and not the local breaker positions. The procedure step 8.8.4 requires more than one action in a step which contributed to the misreading of the step.
- 3) When the operator realized his error, the step was performed again, completing the requirements. The operator was counselled by the Plant Supervisor - Nuclear and written statements were forwarded to the Operations Supervisor - Nuclear.
- 4) OP 3204.1 is being re-written to ensure each step is user friendly. The procedure is presently in the review process.
- 5)
 - a) Full compliance for item 3 above was achieved by October 10, 1985.
 - b) Full compliance for item 4 above will be achieved by December 31, 1985.



FINDING 1.b:

OP 4-OP-013, dated August 28, 1985, entitled Instrument Air System, requires, in section 6.1, that Unit 4 instrument air be routed through the Unit 3 instrument air system dryers when the Unit 4 instrument air dryers are taken out of service.

Contrary to the above, on September 20, 1985, section 6.1 of 4-OP-013 was not implemented, in that the Unit 4 instrument air dryers were taken out of service without routing the Unit 4 instrument air through the Unit 3 instrument air system dryers.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) When the Unit 4 instrument air dryer attempted to automatically swap to the standby dryer, a four way valve malfunctioned causing a loss of instrument air. Operations personnel bypassed the dryer and isolated it to stop the reduction of air pressure. This evolution was documented in the Plant Supervisor - Nuclear (PS-N) log book, however, the required sections of 4-OP-013 were not completed.
- 3) During the 0730 shift turnover on September 20, 1985, the PS-N's discussed the Unit 4 instrument air dryer lineup and decided to realign Unit 4 instrument air through the Unit 3 instrument air dryer as per 4-OP-013. The PS-N was counselled concerning the need to have complete documentation.
- 4) The need to have complete documentation was discussed at shift meetings. A training brief describing the preferred instrument air dryer alignments has been prepared.
- 5) a) Full compliance for item 3 above was achieved by October 28, 1985.
b) Full compliance for item 4 above was achieved by October 21, 1985.

FINDING 1.c:

Administrative Procedure (AP) 0-ADM-503, dated July 10, 1985, entitled Control and Use of Temporary System Alterations, requires, in section 3.6.2, the performance of quarterly reviews of temporary system alterations (TSA). Section 5.5.3 of AP 0-ADM-503 requires that the TSA log tracking sheets be updated following the implementation of a TSA. Section 5.6.1 of AP 0-ADM-503 requires that the Plant Nuclear Safety Committee review TSA's within 14 days of the performance date.

Contrary to the above, prior to October 3, 1985, AP 0-ADM-503 sections 3.6.2, 5.5.3, and 5.6.1 were not implemented, in that the procedural requirements of each section were not met.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the violation was a failure to fully implement the requirements of existing Administrative Procedures governing the Control and Use of Temporary System Alterations. The procedures in effect had been written to cover all system alterations including maintenance on out of service (OOS) equipment, alterations required for troubleshooting and long-term corrective actions. This resulted in numerous Temporary System Alterations (TSA's) being generated for items which were not alterations to in-service safety related plant equipment. These TSA's were also not plant changes or modifications since the equipment was out of service and was returned to service in its original configuration. All of the above activities resulted in a complicated system which was difficult to adequately control. The missed quarterly review (section 3.6.2), the lack of updating of TSA log sheets (section 5.5.3) and the failure of the Plant Nuclear Safety Committee (PNSC) to review TSA's within 14 days (section 5.6.1) were all caused by the inadequate implementation of this procedure.
- 3) Immediate corrective action taken to resolve discrepancies in the implementation of the TSA procedure included a complete inventory and reconciliation of the TSA log, PNSC review of all outstanding TSA's which had not been previously reviewed by the PNSC, completion of the TSA quarterly review.
- 4)
 - a) To prevent further violations, the procedure for the Control and Use of Temporary System Alterations is being revised. The revised procedure will include a more precise definition of what constitutes a temporary system alteration and will provide additional guidance for the control of maintenance activities which are not TSA's. The new procedure will also require PNSC approval of all valid TSA's prior to implementation and post installation testing to verify functionality of the TSA. Previous attempts to modify this procedure were unsuccessful because of a failure to recognize the routine control of maintenance as it related to system alterations. The new procedure will more effectively address all of the issues and will control the use of TSA's.
 - b) In addition, training will be conducted for appropriate plant personnel on the implementation of the revisions made to the TSA procedure described in item 4.a above.
- 5)
 - a) Full compliance for item 3 above was achieved by November 8, 1985.
 - b) Full compliance for item 4.a above will be achieved by January 31, 1986.
 - c) Full compliance for item 4.b above will be achieved by March 31, 1986.

FINDING 2:

TS 6.5.1.6.d requires that the Plant Nuclear Safety Committee (PNSC) review all proposed changes or modifications to plant systems or equipment that affect nuclear safety.

Contrary to the above, prior to October 3, 1985, numerous TSA's, constituting temporary nuclear safety related equipment changes or system modifications, were not reviewed by the PNSC until after they were installed in the plant.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the violation was the incorrect interpretation that Technical Specification requirements for PNSC review of temporary procedure changes within 14 days of implementation (TS 6.8.3) also applied to the review of Temporary System Alterations (TSA's).
- 3) Corrective actions were initiated to assure that system alterations to in-service safety related equipment were adequately reviewed by the PNSC prior to implementation. A complete inventory and reconciliation of outstanding TSA's was completed and all TSA's not previously reviewed by the PNSC were reviewed.
- 4)
 - a) To prevent further violations, the TSA procedure will be revised to assure that alterations made to in-service safety related equipment are reviewed and approved by the PNSC prior to implementation.
 - b) In addition, training will be conducted for appropriate plant personnel on the implementation of the revisions made to the TSA procedure described in item 4.a above.
- 5)
 - a) Full compliance for item 3 above was achieved by October 9, 1985
 - b) Full compliance for item 4.a above will be achieved by January 31, 1986.
 - c) Full compliance for item 4.b above will be achieved by March 31, 1986.

FINDING 3:

10 CFR 50, Appendix B, Criterion XVI, as implemented by FPL Topical Quality Assurance Report (FPL-NQA-100A) Revision 7, TQR 16.0, Corrective Action, requires, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.

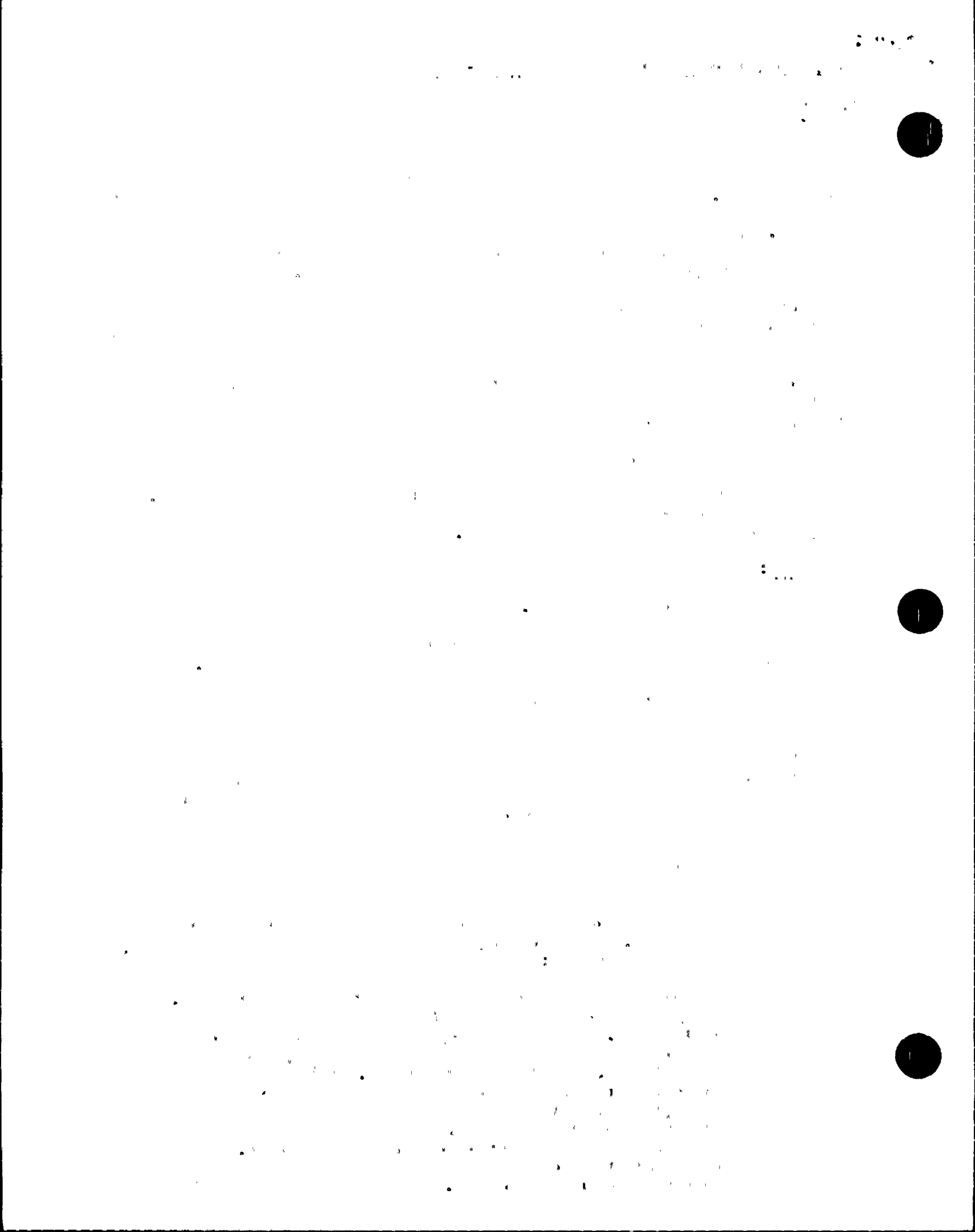
FPL Quality Assurance Manual, Quality Procedure (QP) 16.1, Revision 8, delineates requirements for assuring that conditions adverse to quality are corrected.

AP 0190.13, dated May 21, 1985, entitled Corrective Action for Conditions Adverse to Quality, itemizes the mechanisms by which conditions adverse to quality are promptly identified, tracked and corrected.

Contrary to the above, the licensee failed to establish measures to assure that conditions adverse to quality were promptly identified and corrected, in that the licensee's corrective action program was implemented in a manner which allowed symptom correction without requiring the identification, evaluation and correction of the source problem. Consequently, on June 23, 1985, the B auxiliary feedwater (AFW) pump failed its operability test, tripping twice on electronic overspeed, and maintenance repairs resulted in symptom correction rather than root cause identification and repair. As a result, the B AFW pump again tripped on electronic overspeed on July 2, 1985. Subsequent testing revealed that the electronic overspeed trip occurred prior to the required setpoint. The licensee did not fully address the reason for the June 23 overspeed trips until the problem recurred in July.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The cause of this violation was failure of personnel to adequately assess the root cause of overspeed trips on the B AFW pump. In addition, program requirements were not adequate to assure the root cause was identified and corrected prior to return of the B AFW pump to service.
- 3) Upon determination that the B AFW pump was continuing to trip on overspeed, testing was conducted and the overspeed setpoint was determined to be low. The setpoint was adjusted, the B AFW pump tested and returned to service.
- 4) a) Due to the high impact of the problems experienced during the time period concerning this finding and a previous finding identified in Inspection Report 250,251/85-26, a task team was formed to review the sequence of events and to determine the cause of the problems and to formulate the appropriate corrective actions. The following items have been implemented as a result of this review:
 - To achieve better plant communication and coordination, a Daily Coordination and a Daily Planning meeting have been implemented. The Plant Supervisor - Nuclear chairs the Coordination meeting and presents plant problems, work accomplished, and planned work needed. This has been highly effective in bringing problems to light such as the FCV-3-2833 problem. Plant management and the maintenance disciplines attend this meeting. The Daily Planning meeting, chaired by the Operations-Maintenance coordinator, sets the high priority work items for the day with any needed discussion to resolve issues.



- A Reliability Task Team has also been established to identify chronic equipment reliability problems to plant management for resolution.
 - Response teams have been established to respond to unplanned plant events. The team reviews the event to determine the root cause, develop adequate corrective actions and ensure that plant resources were used effectively.
- b) The Maintenance Department will review the root cause section of PWOs to identify instances where a particular problem is recurring. If such a case is found, the correction of the problem will be pursued. This will be done on an interim basis until implementation of the Nuclear Job Planning System (NJPS). The NJPS will have the capability to display the job history for components. By February 1986 a pilot program of the NJPS will be put into use. Full implementation of the NJPS is presently scheduled for the second quarter of 1987.
- 5) a) Full compliance for item 3 above was achieved by July 26, 1985.
- b) Full compliance for item 4.a above was achieved by August 15, 1985.
- c) Full compliance for item 4.b above will be achieved by February 28, 1986.

FINDING 4:

TS 3.3.3, requires, in part, that containment isolation valves for phase A containment isolation be operable and that automatic valves be capable of closing within the time frames specified in section XI of the ASME Boiler and Pressure vessel code and applicable Addenda as required by 10 CFR 50.55.a.(g).

Contrary to the above, between June 26 and August 8, 1985, Unit 4C steam generator blowdown isolation valve CV-4-6275C was not operable, in that it was not capable of automatic closure as specified in section 6.6 of the Final Safety Analysis Report. An inappropriate TSA resulted in the inability of the valve to close on a phase A containment isolation signal.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for this violation^Q was a personnel error in determining the requirements for temporarily jumping a phase A signal to a containment isolation valve to effect maintenance on the valve. In addition, inadequate post installation testing procedural requirements caused this error to go undetected for several weeks.

1. The first part of the document is a list of names and dates, which appears to be a roster or a list of events. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.



2. The second part of the document is a large, dense block of text, which appears to be a letter or a report. The text is written in a cursive script and is organized into several paragraphs. The first paragraph is the longest and contains the most detail. The subsequent paragraphs are shorter and appear to be summaries or conclusions. The text is written on a single sheet of paper, and the handwriting is consistent throughout.



3. The third part of the document is another large, dense block of text, which appears to be a letter or a report. The text is written in a cursive script and is organized into several paragraphs. The first paragraph is the longest and contains the most detail. The subsequent paragraphs are shorter and appear to be summaries or conclusions. The text is written on a single sheet of paper, and the handwriting is consistent throughout.



- 3) Upon discovery, immediate corrective action was taken to properly jumper the phase A containment isolation signal to the valve. A revised TSA was initiated and post installation testing was conducted to verify proper valve operation. The incident was reviewed and it was determined that the error appeared to be an isolated incident and not representative of the individual's lack of training or qualifications.
- 4)
 - a) To prevent further violations the procedure for the Control and Use of Temporary Alterations will be revised to more adequately define alterations to in-service safety related equipment and to require post installation and post maintenance testing to be conducted. This new procedure will provide additional controls on TSA's to assure that safety related equipment will perform its intended function with the alterations in place.
 - b) In addition, training will be conducted for appropriate plant personnel on the implementation of the revisions made to the TSA procedure described in item 4.a above.
- 5)
 - a) Full compliance for item 3 above was achieved by August 9, 1985.
 - b) Full compliance for item 4.a above will be achieved by January 31, 1986.
 - c) Full compliance for item 4.b above will be achieved by March 31, 1986.

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